

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0871 251

1. PLACE OF DEATH- COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queene Ann</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Sudlersville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Sudlersville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Elizabeth</u> (Middle) (Last) <u>Anderson</u>	4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>3</u> (Year) <u>1950</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 23-1870</u>
9. AGE last birthday <u>80</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	13. FATHER'S NAME <u>Phillip Graham</u>	14. MOTHER'S MAIDEN NAME <u>Anna Harmon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT <u>Mrs Margaret Graham Sudlersville, Md.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Cardiac Dilatation

Antecedent cause(s) (b) Fall - Chronic Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Shock

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Chronic Arteriosclerosis deformans

19a. DATE OF OPERATION NO 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT (Specify) <u>Accident</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>at home</u>	(CITY OR TOWN) <u>76 Sudlersville</u>	(COUNTY) <u>Qa</u>	(STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) <u>1</u> <u>3</u> <u>51</u> <u>10</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fall &amp; Shock</u>		

22. I hereby certify that I attended the deceased from....., 1920, to....., 1950, that I last saw the deceased

alive on Jan. 3, 1950, and that death occurred at..... 7 P m., from the causes and on the date stated above.

SIGNATURE Edgar L. Lane (Degree or title) MD ADDRESS Sudlersville Md DATE SIGNED 1/6/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan. 6</u>	NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>	LOCATION (City, town, or county) <u>Crumpton</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 6</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR ADDRESS <u>Edgar L. Lane Church Hill, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0826

## CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH- COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lula</u>	(Middle) <u>C.</u>	(Last) <u>Bird</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 7, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>76</u> yrs. If under 1 year Months Days Hours Min. If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornellies Tanner</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Norman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Clark Jewell</u>		<u>Chester, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 175x Immediate cause

## Antecedent cause(s)

Disease or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(a) Adenocarcinoma of left ovary  
 (b) with metastases in urinary bladder

Intensio decursiva, osteo-articular bone lines

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

Myocardial degeneration with  
decompensation

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	<u>decompensation</u>	Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> Not work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Q</u>

22. I hereby certify that I attended the deceased from May 10, 1950 to Jan. 18, 1951; that I last saw the deceasedalive on January 12, 1951, and that death occurred at 5:30 p.m. from the causes and on the date stated above.

SIGNATURE Theodor J. Patterson M.D. ADDRESS Stevensville DATE SIGNED Jan 20/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 21</u>	NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	LOCATION (City, town, or county) <u>Stevensville</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>Elizabeth Foster</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>	ADDRESS <u>Church Hill, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

0827

1. PLACE OF DEATH: COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ruthsburg</u> TOWN <u>Ruthsburg</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ruthsburg - Rural</u> TOWN <u>Ruthsburg</u> STREET ADDRESS <u>W. Centerville</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Ira</u> (Middle) <u>Calloway</u> (Last) <u>Calloway</u>		(Month) <u>January</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct 4, 1873</u>
9. AGE last birthday <u>77</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Calloway</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Harrington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mrs. Katie Calloway, wife</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Mitral Regurgitation</u>		
Antecedent cause(s) (b) <u>Arterio-Sclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1946, to Jan 20, 1951, that I last saw the deceased alive on Jan 20, 1951, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

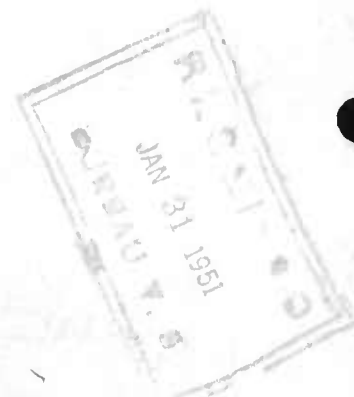
SIGNATURE W. Henry Fisher M.D. (Degree or title) ADDRESS Centerville Md DATE SIGNED 1/22-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 23, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) <u>Easton, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1-22-51</u>	REGISTRAR'S SIGNATURE <u>Oliver Armstrong</u>	24. FUNERAL DIRECTOR <u>Paul Cook</u>	ADDRESS <u>Centerville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Price</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Price</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Dollie</u>	(Middle) <u>V.</u>	(Last) <u>Cecil</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 25, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>70</u> yrs.
13. FATHER'S NAME <u>Louis M. Walls</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hewitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Mrs. Randolph Murphy Price, Md.</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Carcinoma of rt. Breast with metastasis</u>	<u>2 yrs.</u>
170x Antecedent cause(s)	(b)	
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 24, 1959, to January, 1951, that I last saw the deceased alive on Jan. 4, 1951, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

SIGNATURE William C. Lowe MD ADDRESS Queenstown, Md DATE SIGNED 1-13-51

23. BURIAL CREMATION REMOVED <u>Buried</u>	DATE THEREOF <u>Jan. 14</u>	NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>	LOCATION (City, town, or county) (State) <u>Church Hill, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 13</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>	ADDRESS <u>Church Hill, Md.</u>

MARGIN RESERVED FOR BINDING

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Centreville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Centreville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Joseph</u>	(Middle) <u>H.</u>	(Last) <u>Clough</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 4, 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wood-cutting</u>	9. AGE last birthday <u>90 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Clough</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>James Clough Centreville, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10, 1955, to 1-11, 1951, that I last saw the deceasedalive on 1-11, 1951, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Edgar L. Lane

Church Hill, Md.

970826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

U.S. DEPT. OF AGRICULTURE  
JUN 29 1951  
J. A. DAVIS  
WASHINGTON, D. C.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

0830

1. PLACE OF DEATH- COUNTY <u>Town Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Town Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Centerville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Centerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Braconville</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>MARY</u>	<u>KING</u>	<u>COOPER</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 26 - 1913</u>
			9. AGE last birthday <u>37</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Centerville Maryland</u>
13. FATHER'S NAME <u>Welburn King</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Helenita Halli Centerville Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cirrhosis of liverINTERVAL BETWEEN ONSET AND DEATH  
8 mos

## Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 1, 1950, to Jan 9, 1951, that I last saw the deceasedalive on Dec 24, 1950, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. Henry Fisher M.D. Centerville Md1/12-51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 12 - 1951</u>	<u>Chestnutfield Cemetery</u>	<u>Centerville Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1-12-51</u>	<u>Elaine Armstrong</u>	<u>Barton Bros Centerville Maryland</u>	

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CENTRAL OFFICE OF HEALTH

RECEIVED  
JUN 19 1951  
FBI NEW YORK

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0831 251

1. PLACE OF DEATH: COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Vivian</u> (Middle) <u>Green</u> (Last) <u>Green</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 23, 1941</u> 9 yrs. <u>9</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolgirl</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Wm. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Joe Green Chestertown, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pneumonia</u>			
Antecedent cause(s) (b) <u>Influenza</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 4</u> , 19 <u>51</u> to <u>Jan 6</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>51</u> and that death occurred at <u>6:15 p.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>Edgar L. Lane</u>		DATE SIGNED <u>Jan 7, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 8</u>	NAME OF CEMETERY OR CREMATORY <u>Rich Neck</u>	LOCATION (City, town, or county) (State) <u>Near Chestertown, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 7</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> Church Hill, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

0832

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Centreville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Centreville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Alexander</u> (Middle) (Last) <u>Handy</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 17, 1871</u>
9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Steve Handy</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Rebecca Giles</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>John Handy Centreville, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Chronic Heart &amp; Arteriosclerosis</u>			
Antecedent cause(s) <u>hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>93d</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1, 1944</u> , to <u>1-15, 1951</u> , that I last saw the deceased alive on <u>1-14</u> , 19 <u>51</u> , and that death occurred at <u>3:00</u> m., from the causes and on the date stated above.			
SIGNATURE <u>W. H. Matthews</u>		DATE SIGNED <u>1-15-51</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 18</u>	LOCATION (City, town, or county) (State) <u>Rossville Md.</u>
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	

820/05







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH: COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Grasonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Grasonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lottie</u> (Middle) <u>N.</u> (Last) <u>Jones</u>	4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 9, 1877</u>
9. AGE last birthday <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Needles</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Austin Jones Chester, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4201 Immediate cause

(a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis, Cardio-vascular disease(c) Osteo - arthritis

INTERVAL BETWEEN ONSET AND DEATH

Jan. 21, 1951about 4 yearsabout 10 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1949 to Jan. 21, 1951, that I last saw the deceasedalive on Jan. 21, 1951, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

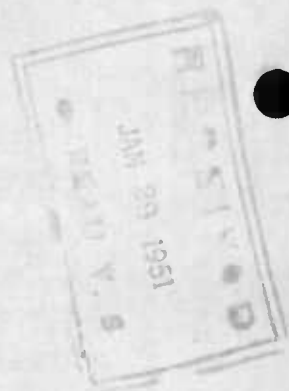
## ADDRESS

Jan. 24 - 1951Helen M. AldridgeEdgar L. LaneChurch Hill, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AJS



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Millington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Millington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>GEORGEANNA</u> (First) <u>MABREV</u> (Middle) (Last)		4. DATE OF DEATH <u>Jan 20</u> 1951 (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 30 1919</u> 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas M. Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Edward Mabrey</u>	
17. INFORMANT AND ADDRESS <u>Rural Kenton Del.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>trauma</u>		
Antecedent cause(s) (b) <u>Chronic Institutional, uroliths</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Malignant Hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic myocarditis</u>		
19a. DATE OF OPERATION <u>20</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>20</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>20</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19, 1951, to Jan 20, 1951, that I last saw the deceased alive on Jan 19, 1951, and that death occurred at 10 P m. from the causes and on the date stated above.

SIGNATURE Edw. Mabrey (Degree or title) MD ADDRESS Fruitersville, Md DATE SIGNED 1/22/51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE Jan 24 1951 NAME OF CEMETERY OR CREMATORY Fruitersville Cem. LOCATION (City, town, or county) (State) Fruitersville MD

DATE REC'D BY LOCAL REG. Jan 22, 1951 REGISTRAR'S SIGNATURE Edgar L. Lane 24. FUNERAL DIRECTOR Edw. Mabrey ADDRESS Millington MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS1A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. <sup>251</sup> 200

1. PLACE OF DEATH - COUNTY <i>Queen Anne's</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>MD.</i> COUNTY <i>Queen Anne's</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Millington</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Ludlowville</i>	
TOWN <i>Millington</i>		TOWN <i>Ludlowville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rebina Nursing Home</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <i>EDWARD</i> (Middle) <i>L.</i> (Last) <i>MARVEL</i>		4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>5</i> (Year) <i>1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 9/1868</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <i>Building Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>	9. AGE last birthday <i>82</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <i>Edward L. Marvel</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Waller</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO.	
		17. INFORMANT AND ADDRESS <i>Paul Phillips Ludlowville Md.</i>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) <i>Chr. myocardial insufficiency</i>	INTERVAL BETWEEN ONSET AND DEATH <i>cent. say.</i>
93d Antecedent cause(s) (b) <i>Generalized Arteriosclerosis</i>	<i>Many years</i>
(c) <i>Mentally Depressed.</i>	

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <i>none</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <i>none</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>—</i>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>none</i> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>—</i>

22. I hereby certify that I attended the deceased from *Jan 2*, 19*51*, to *Jan 5*, 19*51*, that I last saw the deceased alive on *Jan 5*, 19*51*, and that death occurred at *5:15* p.m., from the causes and on the date stated above.

SIGNATURE *H. H. Hamilton* (Degree or title) *MD.* ADDRESS *Millington, Md.* DATE SIGNED *Jan 6/51*

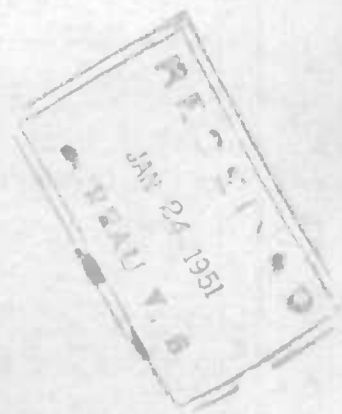
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Jan. 7/1951</i>	NAME OF CEMETERY OR CREMATORY <i>Millington</i>	LOCATION (City, town, or county) <i>Millington Md.</i>
DATE REC'D BY LOCAL REG. <i>Jan. 6, 1951</i>	REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>	24. FUNERAL DIRECTOR <i>Edward Bellows</i>	ADDRESS <i>Millington Md.</i>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

564346



Evidence for change  
of age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## Form No. G 130 JAN 29 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crumpton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crumpton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>L.</u> (Middle) <u>Brent</u> (Last) <u>Owen</u>	4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>4</u> (Year) <u>1950</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 29, 1908</u> 9. AGE last birthday <u>42</u> yrs. If under 1 year Months Days Hours (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>A.B. Owen</u>	
14. MOTHER'S MAIDEN NAME <u>Pye</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Mrs. Helen Owen Crumpton, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of maxillary jaw bone</u>		
Antecedent cause(s) (b) <u>Osteomyelitis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>General anesthesia</u>		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of inferior maxillary</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>W</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>W</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>W</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan 3</u> , 1951, to <u>Jan 4</u> , 1951, that I last saw the deceased alive on <u>Jan 3</u> , 1951, and that death occurred at <u>5 A</u> m. from the causes and on the date stated above.		
SIGNATURE <u>[Signature]</u>	(Degree or title) <u>W D</u>	ADDRESS <u>Inglesville, Md</u> DATE SIGNED <u>1/6/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan. 6</u>	NAME OF CEMETERY OR CREMATORY <u>Crumpton</u> LOCATION (City, town, or county) (State) <u>Crumpton, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 6</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - GRASONVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - GRASONVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NONE</u>		STREET ADDRESS <u>NONE</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) <u>RANSOM</u> (Middle) <u>RANSOM</u> (Last)		4. DATE OF DEATH <u>JAN 20</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>— — 1893</u>
9. AGE last birthday <u>57</u> yrs.		10. AGE last birthday (If under 1 year) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAWN WORK</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>GEORGE M. HEATH, QUEENSTOWN, MD.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) cerebral hemorrhage

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Diabetes mellitusArteriosclerosis(c) chronic nephrosisObesity

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

malignant hypertension (arterial)

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## INTERVAL BETWEEN ONSET AND DEATH

Jan. 13 1951about 2 yearsseveral days

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 26, 1950, to Jan. 20, 1951; that I last saw the deceasedalive on Jan. 19, 1951; and that death occurred at 6:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Theodor Sattelmeier M.D.StevensvilleJan. 22, 1951.

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 24 - 1951Helen M. AldridgeJohn D. Williams, Easton, Md.

970439

MARGIN RESERVED FOR BINDING

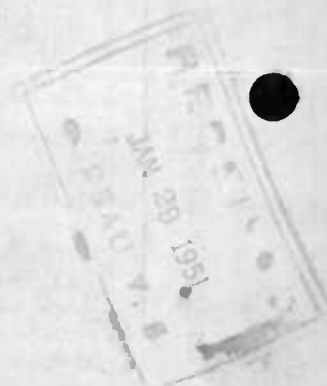
VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE OFFICE OF THE DIRECTOR

OF THE BUREAU OF THE ARMY

OFFICE OF THE DIRECTOR



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 953

1. PLACE OF DEATH- COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Stevensville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Stevensville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Augustus</u>	(Middle) <u>Klebo</u>	(Last) <u>Reamy</u>
4. DATE OF DEATH	(Month) <u>Jan.</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 16, 1874</u>
9. AGE last birthday <u>76</u> yrs.		If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT Country? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Presley Reamy</u>		14. MOTHER'S MAIDEN NAME <u>Angelina Coates</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Presley Reamy</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Hypertension</u>					
Antecedent cause(s) (b) <u>Arterio Sclerosis</u>					
Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last (c) <u>Nephritis</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1948</u> , to <u>Jan 4, 1951</u> , that I last saw the deceased alive on <u>Jan 4, 1951</u> , and that death occurred at <u>1305</u> m., from the causes and on the date stated above.					
SIGNATURE <u>W. O. E. Snyder</u>		(Degree or title)		ADDRESS <u>Stevensville</u>	
DATE SIGNED <u>1/4/51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Jan. 7</u>		NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	
LOCATION (City, town, or county) <u>Stevensville</u>		(State) <u>Md.</u>			
DATE REC'D BY LOCAL REG. <u>Jan 7, 1951</u>		REGISTRAR'S SIGNATURE <u>Elizabeth Koster</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>	
ADDRESS <u>Church Hill, Md.</u>					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



0839

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2.52

1. PLACE OF DEATH: COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>2. Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
TOWN <u>Bethesda</u>		TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>RACHAEL FRANCES RITCHIE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 5 1951</u>	
SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 17 - 1858</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>92</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Talbot Co - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Luther Wyatt</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Dymon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>L. H. Muddick - Bethesda, Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

592x Immediate cause

(a) Chronic Interstitial nephritis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

131a

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arterio-Sclerosis

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY				

22. I hereby certify that I attended the deceased from Jan 1 - 1949, to Jan 5 1951, that I last saw the deceasedalive on Jan 3 1951, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W Henry Fisher M.D.Bethesda Md1/6-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/8/51</u>	<u>Chertified</u>	<u>Bethesda</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1-6-51</u>	<u>Clara Armstrong</u>	<u>Barton Bros - Bethesda</u>	<u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH - COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Centerville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>HANDY</u>	<u>PASTERFIELD</u>	<u>ROBINSON</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>Jan 21</u>	<u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 23-1862</u>
9. AGE last birthday <u>88</u> yrs.	If under 1 year Months	If under 24 hrs. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederickburg, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William H. Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Melvin Robinson, Centerville, Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a)

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1, 1940, to 1-21, 1951; that I last saw the deceasedalive on 1-19, 1951, and that death occurred at 12:29 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

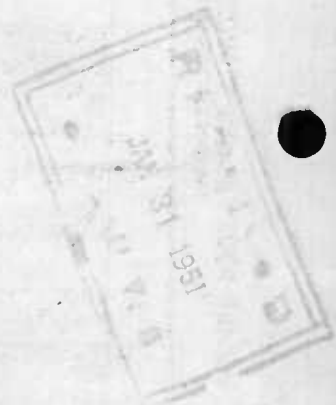
MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105







# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0841 251

1. PLACE OF DEATH: COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Church Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Church Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u>	(Middle) <u>L.</u>	(Last) <u>Seney</u>
4. DATE OF DEATH	(Month) <u>Jan.</u>	(Day) <u>9</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 11, 1881</u> 69 yrs.
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm-Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Seney</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Beatrice Seney Church Hill, Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Patrol 11 rectal bleed</u>	<u>Death</u>
Antecedent cause(s) (b) <u>None</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
(CITY OR TOWN) <u>Church Hill</u>	(COUNTY) <u>Queene Anne</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>10:49 P</u> , 19 <u>51</u> , to <u>10:49 P</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>10:49 P</u> , 19 <u>51</u> , and that death occurred at <u>10:49 P</u> , 19 <u>51</u> , from the causes and on the date stated above.	
SIGNATURE <u>Edgar L. Lane</u>	DATE SIGNED <u>1.11.51</u>
23. BURIAL, CREMATION REMOVE <u>Buried</u>	DATE THEREOF <u>Jan. 11</u>
NAME OF CEMETERY OR CREMATORY <u>Salem</u>	LOCATION (City, town, or county) (State) <u>Church Hill, Md.</u>

DATE REC'D BY LOCAL REG. <u>Jan. 11</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR ADDRESS <u>Edgar L. Lane Church Hill, Md.</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970116



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u> TOWN <u>Stevensville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>all life</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Queen Anne's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u> TOWN <u>Stevensville</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>SARAH JANE SPARKS</u>		(First) <u>SARAH</u>		(Middle) <u>JANE</u>	
(Last) <u>SPARKS</u>		4. DATE OF DEATH <u>Jan. 31, 1967</u>		(Month) <u>Jan.</u> (Day) <u>31</u> (Year) <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 24, 1862</u>	9. AGE last birthday <u>88</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. Kind of Business or Industry <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Lawrence Hart</u>		14. MOTHER'S MAIDEN NAME <u>Susan Harman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Hunt Taylor Brookline Mass.</u>	

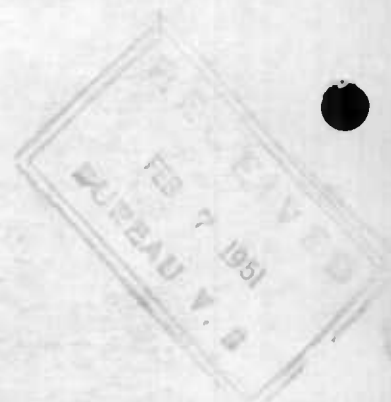
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cardiac Failure</u>			
Antecedent cause(s) (b) <u>Cerebral Thrombosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension - Arterial Sclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Leukemia</u>			
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>Leukemia</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	

22. I hereby certify that I attended the deceased from May, 1945, to Jan. 31, 1967, that I last saw the deceased alive on Jan. 27, 1951, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE: <u>Dr. D. D. D. D. D.</u>		(Degree or title) <u>MD</u>		ADDRESS <u>Stevensville Md.</u>		DATE SIGNED <u>2/1/51</u>	
23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Stevensville Cem.</u>		LOCATION (City, town, or county) (State) <u>Stevensville Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 2, 1951</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Kane</u>		24. FUNERAL DIRECTOR <u>Edward Bellows</u>		ADDRESS <u>Wilmington Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH: COUNTY <u>Green Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesler</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesler</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Henrietta</u>	(First) <u>R</u> (Middle) <u>Stensburg</u> (Last)	4. DATE OF DEATH	(Month) <u>Jan</u> (Day) <u>22</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr 17-1851</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>85</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>Richard K Dunn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Henrietta E Green</u>		14. INFORMANT AND ADDRESS <u>Oscar Dunn Chesler Md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause

(a) Nephro - Sclerosis chronic with uremiaINTERVAL BETWEEN ONSET AND DEATH Dec. 14, 1950

131.6 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arterio sclerosis general + cerebralaboutmyocardial degeneration, senility10 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

cerebral accidentJuly 1941

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 14, 1950 to Jan. 22, 1951, that I last saw the deceasedalive on Jan. 21, 1951, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	<u>Jan 24-51</u>	<u>Deaths Neck</u>	<u>Stevensville</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 24-1951</u>	<u>Elizabeth Kapter</u>	<u>Stevensville</u>	<u>Emory Campbell, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

77 81  
- 53  
1951



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Queenstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Queenstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Frances</u> (Middle) <u>Elmer</u> (Last) <u>Story</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 18 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 24, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newswork</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>86</u> yrs. If under 1 year: Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.
13. FATHER'S NAME <u>Robert Gamble</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY No. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wardell</u>	
17. INFORMANT AND ADDRESS <u>Blanche Gerlach, Queenstown, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arteriosclerotic Cardiovascular Disease</u>			<u>2 mos.</u>
Antecedent cause(s) (b) <u>102.1</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nev., 1950, to Jan., 1951, that I last saw the deceased alive on Jan. 18, 1951, and that death occurred at 9:10 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan 20-1951</u>	<u>Cheslerfield</u>	<u>Centerville Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>Jan. 19-1951</u>	<u>Robert M. Adedridge</u>	<u>Barton Bros Centerville Maryland</u>		

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13



RECEIVED  
JUL 29 1951  
U.S. AIR FORCE